Texas Department of Insurance
Division of Workers' Comp
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SURGERY SPECIALTY HOSPITAL OF AMERICA
S E HOUSTON CAMPUS
4301 VISTA ROAD
PASADENA TX 77504

Respondent Name

AMERICAN HOME ASSURANCE COMPANY

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-10-2642-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "In regards, to ANSI reason code '147/45', the Carrier has not provided any evidence to support this denial code. The healthcare provider does not have a contractual negotiated agreement with Carrier as stated in their EOB nor is one noted." "If calculated pursuant to sections §134.404(f)(1)(B) and (g), reimbursement should be **$45,440.67** and calculated as follows: **Surgery Specialty Hospitals of America, S.E. specific (see attached Medicare In Patient pricer) DRG value/outlier $21,881.55 x 108% = $23632.07 + $21,808.60 (Implant at cost plus 10% or $2,000.00 cap) = $45440.67 Total Amount.**" "The Carrier made a partial payment of **$38,714.46**. Therefore, the Carrier is required to reimburse Provider in the amount of **$6,726.21**, plus any and all applicable interest."

Amount in Dispute: $20,341.01

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Since the provider's original request for Medical Review, the carrier in this matter has re-reviewed the charges in dispute, which are for dates of service 1/28/09-1/30/09. Carrier has now determined that an additional $291.51 should be paid for an additional implant in addition to the $38,714.46 that the carrier previously paid." "Carrier did not apply any PPO contract discount to the reimbursement."

Response Submitted by: Flahive Ogden & Latson, 504 Lavaca, Suite 1000, Austin, Texas 78701

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 28, 2009 Through January 30, 2009	Inpatient Hospital Surgical Services	$20,341.01	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.404 sets out the guidelines for reimbursement of hospital facility fees for inpatient services.
3. 28 Texas Administrative Code §134.404(e) states that: "Except as provided in subsection (h) of this section, regardless of billed amount, reimbursement shall be:
   (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or
   (2) if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any applicable outlier payment amounts and reimbursement for implantables."
   (3) If no contracted fee schedule exists that complies with Labor Code §413.011, and an amount cannot be determined by application of the formula to calculate the MAR as outlined in subsection (f) of this section, reimbursement shall be determined in accordance with §134.1 of this title (relating to Medical Reimbursement).
4. 28 Texas Administrative Code §134.404(f) states that "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.
   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
      (A) 143 percent; unless
      (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent."
5. 28 Texas Administrative Code §134.404(g) states that "Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission."
6. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated May 19, 2008 [sic]
   - 147 – Provider contracted/negotiated rate expired or not on file.
   - 45 – Charges exceed your contracted/legislated fee arrangement.
   - W1 – Workers Compensation State Fee Schedule Adjustment

   Explanation of benefits dated December 11, 2009
   - B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment.
   - W3 – Additional payment made on appeal/reconsideration.
   - W1 – Workers Compensation State Fee Schedule Adjustment

Issues

1. Were the disputed services subject to a specific fee schedule set in a contract between the parties that complies with the requirements of Labor Code §413.011?
2. Can the maximum allowable reimbursement (MAR) amount for the disputed services be determined according to 28 Texas Administrative Code §134.404(f)?
3. Did the facility or a surgical implant provider request separate reimbursement for implantables in accordance with 28 Texas Administrative Code §134.404(g)?
4. Is the requestor entitled to additional reimbursement for the disputed services?

Findings

1. The respondent submitted an Affidavit affirming that there was no contract between the parties in this dispute.
2. Review of the submitted documentation finds that the maximum allowable reimbursement (MAR) amount for the disputed services can be determined according to 28 Texas Administrative Code §134.404(f).
3. Review of the submitted documentation finds that separate reimbursement for implantables was requested in

accordance with 28 Texas Administrative Code §134.404(g).

4. Reimbursement for the disputed services is calculated in accordance with 28 TAC §134.404(f)(1)(B) as follows:

   The Medicare facility-specific reimbursement amount including outlier payment amount for the disputed services (not including implantables) billed under DRG 460 is $21,811.55.

   This amount multiplied by 108% is $23,556.47.

   The total net invoice amount (exclusive of rebates and discounts) for the disputed implantables is $13,780.00.

   The total add-on amount of 10% or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission is $1,378.00.

   The total maximum allowable reimbursement (MAR) is $38,714.47.

   This amount less the amount previously paid by the respondent of $39,005.97 leaves an amount due to the requestor of $0.00.

   The Division concludes that the requestor is not entitled to additional reimbursement.

Conclusion

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 13, 2011 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.